Beth Israel Deaconess Hospital
Plymouth

AUTHORIZATION TO USE AND/OR DISCLOSE LABORATORY MEDICAL INFORMATION

(Sections 2-8 must be completed.)

1. I hereby authorize Beth Israel Deaconess Hospital-Plymouth ("BID-Plymouth"), to use and/or disclose the following protected health information ("PHI") from the laboratory records of the patient listed below. I understand that the information used and/or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient Name:** _____ **Date of Birth:** _____

   Address: _____
   Street City State Zip

   Phone Number: _____

3. **Laboratory Information to be disclosed to:** _____
   Name

   Address: _____
   Street City State Zip

4. **Disclose the following laboratory medical information for dates:** _____ to _____:

   ☐ Laboratory ☐ Pathology ☐ Other (specify) _____

5. The above information is disclosed for the following purpose: ☐Medical Care ☐Legal ☐Insurance ☐Personal

6. The means of delivery for the above information: ☐In person ☐Mail

7. I understand I may **revoke this authorization** at any time by requesting such of the above-referenced hospital, physician, or facility, in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization **expires** after ninety (90) days from the date I signed it unless otherwise specified.

   _____ _____
   Signature of Patient or Legal Representative Date

   _____ _____
   Printed name of Patient or Legal Representative Relationship to Patient or authority to act for patient **(attach documentation)**

8. I understand that my record may contain information in reference to treatment for substance abuse and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, HIV/AIDS, or other sensitive information. I agree to its release unless otherwise specified (please explain).

   _____ _____
   Signature of Patient or Legal Representative Date

   _____ _____
   Printed name of Patient or Legal Representative Relationship to Patient or authority to act for patient **(attach documentation)**

SIGNATURE OF EMPLOYEE RELEASING RECORD/S_____ DATE: _____

(NOTE: Please scan photo identification and completed form. DO NOT scan form until complete. Direct all individuals other than the patient to the Medical Records Department.)